

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Dominic Baratta			2a. DATE OF DEATH Month Day Year June 7 68			2b. HOUR 6:10 PM							
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-3-94		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.							
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VAH Perry Point, Md.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey			13b. COUNTY E. Patterson		13c. CITY OR TOWN E. Patterson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 286 Boulevard St.				
14. FATHER'S NAME First Middle Last Batsy Baratta			15. MOTHER'S MAIDEN NAME First Middle Last Filomena Battinelli										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW1			16b. SOCIAL SECURITY NO. 151 03 8690		17. INFORMANT Address VA Hospital records Perry Point, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis probably secondary 4109 DUE TO, OR AS A CONSEQUENCE OF to Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 seconds													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes Mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from Sept. 28, 19 67 , to June 7, 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Michael Ereshevich						22c. DATE SIGNED 6-8-68							
22d. PHYSICIAN'S NAME (Type) MICHAEL ERESHEVICH, M.D.						22e. ADDRESS VA Hospital, Perry Point, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 6/12/68		23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery			23d. LOCATION (City or Town) (County) (State) Perry Point, Cecil, Md.					
24. FUNERAL DIRECTOR Cerrone			ADDRESS San Harold, Md.			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE JUN 11 1968	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <u>Jimmy Dee Barrett</u>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <u>6-30</u> 19 <u>68</u>			2b. HOUR <u>1 P.M.</u>		
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>3-23-61</u>	6. AGE (In years last birthday) <u>7</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u>	IF UNDER 24 HRS HOURS <u>0</u>	2c. DATE PRONOUNCED DEAD Month <u>6</u> Day <u>30</u> Year <u>1968</u>			2d. HOUR <u>1:55 P.M.</u>		
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Cecil</u>					
10. CITY OR TOWN OF DEATH <u>Elkton, Md.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>D.O.A. Union Hosp.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Student</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>school</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <u>Md.</u>			13b. COUNTY <u>Cecil</u>		13c. CITY OR TOWN <u>Elkton</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>R.D. 1, Box 348</u>		
14. FATHER'S NAME First <u>Edward</u> Middle <u>Huey</u> Last <u>Barrett</u>				15. MOTHER'S MAIDEN NAME First <u>Helen</u> Middle <u>Frances</u> Last <u>Nowland</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Edward H. Barrett (father), Elkton, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>9298</u>											
19a. DATE OF OPERATION <u>9/100</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <u>1:00 P.M. 6-30 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u>In water over head - unable to swim</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) <u>North East River</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Elk Neck State Park, nr. North East, Cecil, Md.</u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John M. Byers</u>		EXAMINER'S NAME (Type) <u>John M. Byers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6-30-68</u>	
ADDRESS (Street, city, town, or county) <u>Elkton, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7/3/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ELKTON, CECEL MD</u>					
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL - 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Claude C. Brooks						6 Month 17 Day 68		2:10 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		July 28, 1895		72 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Delaware		USA				Cecil Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			Mail carrier				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Delaware			New Castle		Glasgow		YES		Newark RD# 1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William C. Brooks			Mary E. Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes			WW 1		Mrs. Elizabeth M. Brooks Glasgow, Del.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444.2 GANGRENE, Small bowel									2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Occlusion Superior mesenteric Artery									2 days	
(c) Arterio sclerosis									5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
5702										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
6/17/68		GANGRENE bowel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 5/15, 1968, to 6/17, 1968, that (I) (we) last saw the deceased alive on 6/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				22c. DATE/SIGNED						
John A. Fischer				6/18/68						
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
John A. Fischer				Eckton, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/20/68		Gracelawn Mem. Park		Farnhurst N.C. Del.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
K.T. Jones Newark, Delaware				DATE JUN 20 1968		Charles Judge				

DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b' <u>53 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD #4, Box 53</u>				d. STREET ADDRESS <u>RFD #4, Box 53</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT</u> <u>Alexander</u> <u>CHEVREUIL</u>				4. DATE OF DEATH Month Day Year <u>10</u> <u>10</u> <u>1968</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/1915</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henri Chevreuil</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. NELLIE CHEVREUIL</u> Address <u>Elkton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109 MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ACUTE CORONARY OCCLUSION</u> DUE TO (c) <u>CORONARY HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201 CEREBRAL VASCULAR SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 min?</u> <u>15 min?</u> <u>12 min?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> , 19 <u>68</u> , to <u>6/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June</u> 19 <u>68</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Peter Staurakis</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>6/10/68</u>			
22c. PHYSICIAN'S NAME (Type) <u>PETER STAURAKIS MD</u>				22d. ADDRESS <u>ELKTON MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Elkton, Md.</u>	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
George		S	Clark		June 2 1968		8:45 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		9-18-93		74		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Cecil Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Perryville		VAH Perry Point, Md.		Salesman		Food ind.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		P.G. ✓		New Carrollton				7600 Fontaine Bleu Drive.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
George		W.	Clark		Elizabeth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) Yes		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes		WW 1		212-03-0993		VA Hospital Records Perry Point, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 <u>Diabetes mellitus</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15, 1967</u> , to <u>June 2, 1968</u> , that (I) (we) (we) (did) view the body after death.								
22b. SIGNATURE <u>A. L. Mooney, M.D.</u>						22c. DATE SIGNED 6-3-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
A. L. MOONEY, M.D.		VAH, Perry Point, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		6/6/68		Burrhead Co. Mem		Burrhead Co. Pa		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Perryville & Son Funeral Home, Havre de Grace		Maryland		DATE JUN 6 1968		Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Ralph			Franklin Cullum			Month Day Year June 11 1968			4:45 P M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		8-10-07			60 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland			USA						Cecil				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point			VAH Perry Point, Md.			Mechanic, auto.			Auto.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
Maryland			Harford			Abingdon			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			257 Baker Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Amos J. Cullum			Gertrude A. Cullum										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
Yes			WW 2			217-26-3646			VA Hospital records.			Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>											4-7 days		
4129 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u>											4-7 days		
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>myocardial febrrosis</u>													
(c) <u>Arteriosclerotic heart disease w/extensive</u>											7 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4200													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 7</u> , 19 <u>68</u> , to <u>June 11</u> , 19 <u>68</u> , that (I) (we) (we) viewed the deceased on <u>June 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE									22c. DATE SIGNED				
A. L. MOONEY, M.D.									6-12-68				
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS				
A. L. MOONEY, M.D.									VAH, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			June 15, 1968			Bel Air Memorial Gardens			Bel Air Harford Md				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Howard K. McComas & Son, Abingdon, Md.						DATE JUN 14 1968			Charles Judge				

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. L. MOORE, JR.		1-15-1915		M		W		Married		Farmer		Heart Disease w/ extensive		Home		1-15-66		10:30 AM		J. L. MOORE, JR.		J. L. MOORE, JR.	
Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Cause of Death		Place of Death	
1-15-66		10:30 AM		J. L. MOORE, JR.		J. L. MOORE, JR.		Heart Disease w/ extensive		Home		1-15-66		10:30 AM		J. L. MOORE, JR.		J. L. MOORE, JR.		Heart Disease w/ extensive		Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Thelma					M. Davis					June 18, 1968					2:10 AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Female			White			Aug. 18, 1913			54 YRS.			MONTHS DAYS			HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Virginia					U.S.A.										Cecil Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Elkton					Union Hospital										R.M.R. Corp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER				
Maryland					Cecil					Elkton					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					128 Friendship Road				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Henry Henson					Colby Wolford																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No					227-40-8776					Leonard H. Davis					Elkton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <u>Uremia</u>															1 month									
180X DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
(b) <u>Carcinoma of cervix uteri</u>															2 years									
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																								
171X																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
1966					Carcinoma cervix																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>68</u> , to <u>6/18</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>6/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
<u>John A. Fischer</u>															6/20/68									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
John A. Fischer															Elkton, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					June 21, 1968					Gilpin Manor Mem Park					Elkton Maryland									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Ralph E. Hicks															DATE JUN 26 1968					Charles Judge				
Hicks Home for Funerals, Elkton, Md.																								

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			
PERRY			L. DOUGLAS			6 3 68 8:05am			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		6-12-93		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Cecil Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Perry Point		Veterans Administration		Laborer Ret.		Construction			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Cecil		Cecilton				None	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
George Douglas (D)			Priscille Price (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes WW I			218-03-7861		VA Hospital Records, Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Prostate Gland with bony</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF <u>Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>177X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (X) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>68</u> to <u>June 3</u> , 19 <u>68</u> , that (X) (we) (we) saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>I. Reus MD</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>6-3-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>I. REUS, M.D.</u>						22e. ADDRESS <u>VA Hospital, Perry Point, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June, 8, 1968		Cecilton Cemetery		Cecilton, Cecil, Md.			
24. FUNERAL DIRECTOR <u>Fellows Funeral Home</u> ADDRESS <u>Millington, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUN 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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THE UNIVERSITY OF CHICAGO

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TABLE 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | |
|--|-------------------------|--|---|---|
| 1. DECEASED-NAME
(Type or print) WALTER B FISHER, Jr. | | 2a. DATE OF DEATH
Month 6- Day 10- Year 68 | | 2b. HOUR
1:30AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
9-14-06 | | 6. AGE (In years last birthday)
61 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Perryville, Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Cecil | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Perryville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VAH, Perry Point, Md. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Cecil | 13c. CITY OR TOWN
Perryville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET AND NUMBER
Cecil Ave. | | | | |
| 14. FATHER'S NAME First Middle Last
unknown | | 15. MOTHER'S MAIDEN NAME First Middle Last
unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown (If yes give year or dates of service)
Yes WW II | | 16b. SOCIAL SECURITY NO.
214-14-7589 | | 17. INFORMANT Address
VA Hospital Records, Perry Point, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident - hemorrhage.
4120
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443x
(b) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized arteriosclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
28 yrs.
28 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CBS due to previous CVA with right hemiparesis. Repeated GU infections. | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23-68 , 19 68 , to 6-10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
T. R. Huxtable, M.D. | | 22c. DATE SIGNED
June 10, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
T. R. HUXTABLE, M.D. | | 22e. ADDRESS
VAH, Perry Point, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/12/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Erin Cemetery |
| 23d. LOCATION (City or Town) (County) (State)
Havre de Grace Harford Md. | | | | |
| 24. FUNERAL DIRECTOR
Lee A. Patterson & Son Funeral Home, | | 25. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
JUN 18 1968 |

12282

25587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 08358 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08362 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|-----------------------------------|---|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Arthur William GIBBONS, Jr. | | | | | | Month Day Year
June 2 1968 | | | 8:25 A.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | Caucasian | | December 30, 1920 | | | 47 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Cecil County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bainbridge | | | Station Hospital | | | U. S. Navy | | | Military | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Cecil | | | Port Deposit | | | | 201 D Laffey Circle, Heights | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last
Arthur William GIBBONS, Jr. | | | First Middle Last
Cora Estelle BRUCHEY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| Yes 1942 - 1968 | | | 217 03 2263 | | Naval Training Center, Bainbridge, Md. | | | 19352 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201
(b) CONGESTIVE HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
EMPHASEMA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| - | | --- | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | NA | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June 2</u> , 19 <u>68</u> , to <u>June 2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (the hospital) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Sol Rockenmacher MD</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>6/3/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
SOL ROCKENMACHER, LT MC USNR | | | | | | 22e. ADDRESS
Station Hospital, NTC, Bainbridge, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 6/5/1968 | | Arlington National Cemetery | | | Arlington, Virginia | | | | |
| 24. FUNERAL DIRECTOR
LEE A. PATTERSON & SON, PERRYVILLE, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 11 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

11-1832

60325



RECEIVED
JAN 10 1962
U.S. AIR FORCE
HONOLULU, HAWAII
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which are bolded, but the specific words and phrases cannot be accurately transcribed.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08359

08363

| | | | | | | | | | |
|---|--|--|--------|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month 6 Day 3 Year 68 | | 2b. HOUR
9:15am | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12-14-95 | | 6. AGE (In years
last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Sterling, Col. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil Md. | | | |
| 10. CITY OR TOWN OF DEATH
Perry Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Veterans Administration | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Printer | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
D.C. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
920 F S reet, NW | |
| 14. FATHER'S NAME
Martin | | First Middle Last
Griffith(D) | | 15. MOTHER'S MAIDEN NAME
Mary Griffith (D) | | First Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes WW I | | 16b. SOCIAL SECURITY NO.
579-28-7192 | | 17. INFORMANT
VA Hospital Records, Perry Point, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema, Acute.
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) Arteriosclerotic Coronary Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis, Generalized. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Cerebral Arteriosclerosis, Severe. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (this hospital) attended the deceased from Oct. 4, 1966, to June 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
A. L. Mooney, M.D. | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
6-3-68 | |
| 22d. PHYSICIAN'S NAME (Type)
A. L. MOONEY, M.D. | | | | | | 22e. ADDRESS
VA Hospital, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
10-7-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
Patterson Funeral Home, Perryville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JUN 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 08360 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 08364 | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Lucy MAY Hansen | | | | 2a. DATE OF DEATH Month Day Year
JUNE 13 1968 5:45 PM | | | | 2b. HOUR | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
20 April 1889 | | | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
CALVERT | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CALVERT MAJOR NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housework | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Housekeeper | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
PENNA | | 13b. COUNTY
Chester | | 13c. CITY OR TOWN
Oxford | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
PENN AVE. | | | |
| 14. FATHER'S NAME First Middle Last
CLAYTON BELTZ | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARY Louise Disley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
211-20-2798 | | 17. INFORMANT
Richard L. Goodie | | | | Address
Rising Sun, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
437.9 IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days
8 yrs. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-5, 1961, to 6-13, 1968, that (I) (we) last saw the deceased alive on 6-10, 1968, and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Neil R. Taylor | | DEGREE
F.R.M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6-13-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Neil R. Taylor | | 22e. ADDRESS
Rising Sun, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
17 June 68 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. John's M.E. | | 23d. LOCATION (City or Town) (County) (State)
Lewisville Cecil Md. | | | | | |
| 24. FUNERAL DIRECTOR
William J. Johnson | | ADDRESS
Oxford Pa. | | 25a. REC'D BY REGISTRAR
DATE JUN 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin-bottom: 5px;">AM</div> <div style="font-size: 2em; margin-top: 5px;">1</div> </div> <div> <div style="font-size: 1.5em; margin-bottom: 5px;">08361</div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div style="font-size: 1.2em;">CERTIFICATE OF DEATH</div> </div> <div style="font-size: 1.5em; margin-top: 5px;">08365</div> </div> </div> | | | | | | | | | | | |
|--|--|--|--|--|-------------------------------------|--|--|--|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) <u>WALTER J. HINES</u> | | | | | | 2a. DATE OF DEATH <u>6</u> Month <u>2</u> Day <u>68</u> Year | | | 2b. HOUR <u>10:00AM</u> | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>Aug. 18, 1894</u> | | | 6. AGE (In years lost birthday) <u>73</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <u>XXXX Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Cecil</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Elkton</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Union Hospital</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Caretaker</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Estate</u> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | | 13b. COUNTY <u>Cecil</u> | | 13c. CITY OR TOWN <u>North East</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <u>R.D. 2</u> | | |
| 14. FATHER'S NAME First Middle Last <u>Phillip Hines</u> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <u>Albertha Lilley</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. <u>183-26-0266</u> | | 17. INFORMANT <u>Florence M. Hines</u> | | | Address <u>R.D. 2 North East, Md.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ARGENTAFFIN Tumor, Cecum</u>
<u>230.3</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>230x</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>5/24/68</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cecal Tumor</u> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , 19 <u>68</u> , to <u>6/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>John A. Fischer</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>6/2/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>John A. Fischer</u> | | | | | | 22e. ADDRESS <u>ELKTON, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>6-5-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>North East Cecil Md.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Paul R. Louch</u> ADDRESS <u>Box 22 North East, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>JUN 4 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



INSTITUTE OF DATA

TO THE DIRECTOR, INSTITUTE OF DATA

FROM THE DIRECTOR, INSTITUTE OF DATA

RE: [Illegible]

DATE: [Illegible]

INSTITUTE OF DATA
100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Mary A. Hollett | | | | | | June 8, 1968 | | 6 P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | October 4, 1885 | | 82 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Delaware | | USA | | | | Cecil | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Elkton | | | Union Hospital | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Cecil | | Elkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Elkton RD# 4 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last
Mary Daniel A. Sweeney Hollett | | | First Middle Last
Sara Jane Quinn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 222-09-6797 | | Mrs. Harvin Onizuk Elkton, Md. RD# 4 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Coma</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of the Liver</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of Thyroid, Spleen or Colon</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 weeks
1-2 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> , 19 <u>68</u> , to <u>6-8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>John R. Jones</u> | | | | | | | | 22c. DATE SIGNED
June 10, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Nejema | | | | 22e. ADDRESS
Elkton, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | June 12, 1968 | | Chester-Bethel | | Wilmington, Delaware | | | | |
| 24. FUNERAL DIRECTOR
<u>R. T. Jones</u> | | | | ADDRESS
<u>Newark, Delaware</u> | | 25a. REC'D BY REGISTRAR
DATE JUN 12 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

— 33 —

notified by e-mail.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

Submitted: 10/20/01

1995

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08363

08367

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) MARGARET T. KAY | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year JUNE 21 1968 | | 2b. HOUR
5:00 AM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
OCTOBER 23, 1876 | | 6. AGE (In years last birthday)
91 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
CECIL | |
| 10. CITY OR TOWN OF DEATH
ELK MILLS | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
AT HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
CECIL | | 13c. CITY OR TOWN
ELK MILLS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
--- | | 14. FATHER'S NAME
First Middle Last
EDWARD LAMAR | | 15. MOTHER'S MAIDEN NAME
First Middle Last
No INFO | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ERNEST E. KAY - ELK MILLS, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4129 IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ASHD
(c) ASHD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks
2 wks
10 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4200 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/5 , 19 68 , to 6/21 , 19 68 , that (I) (we) last saw the deceased alive on 6/21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph Lanzetta | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/21/68 | |
| 22d. PHYSICIAN'S NAME (Type)
JOSEPH LANZETTA | | | | 22e. ADDRESS
ELKTON, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
6-24-68 | | 23c. NAME OF CEMETERY OR CREMATORY
CHERRY HILL CEM. | | 23d. LOCATION (City or Town) (County) (State)
CHERRY HILL CECIL MD | |
| 24. FUNERAL DIRECTOR
W.H. PIPPIN FUNERAL HOME | | | | ADDRESS
Elkton, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
JUN 25 1968 | |

MEDICAL CERTIFICATION

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|--|--|---------|------------------------------|--|--|--|---------------------------------|---|------------------------------|---|------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | | |
| LYMAN | | | LITTLEFIELD | | | KING | | | Month 6 Day 2 Year 68 10:10P | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| Male | | White | | 4-5-92 | | | 76 YRS. | | MONTHS | | DAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | | 9d. Md. | | | |
| D. C. | | | U.S.A. | | | | | | Cecil | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Perry Point | | | | Veterans Administration | | | | Ret. Policeman | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Virginia | | | | | | | | Arlington | | | | 3138 10th Street, Apt. 2-A | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | | | |
| James | | | King (D) | | | Mary | | | Ford (D) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Address | | | |
| Yes | | | | WW I | | | | 229-44-7678 | | | | VA Hospital, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Edema, Acute | | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) Congestive Heart Failure | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) Arteriosclerotic Coronary Heart Disease | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 4201 Pulmonary T.B. Active, Far Advanced. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from May 22, 1968, to June 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE A. L. Mooney, M.D. DEGREE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D. | | | | | | | | | | | | 22e. ADDRESS VA Hospital, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 6-5-1968 | | Oakhill Cemetery | | | | Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR Ives Funeral Home, Wilson Blvd., Arlington, Va. | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE 7 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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101-104 82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|---|--------------------------------|
| 1. DECEASED-NAME
(Type or print)
ANDREW | | | First Middle Last
W. MAIR | | | 2a. DATE OF DEATH
Month Day Year
June 20, 1968 | | | 2b. HOUR
3:40 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
10/9/07 | | | 6. AGE (In years last birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Scotland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Perry Point | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VA Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Pennsylvania | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Ardmore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
209 Marlboro Road | | |
| 14. FATHER'S NAME First Middle Last
Allan Mair | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Euphrenia Wilson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
Yes WWII | | | 16b. SOCIAL SECURITY NO.
160-03-5523 | | 17. INFORMANT Address
VA Hospital Records, Perry Point, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
1419
DUE TO, OR AS A CONSEQUENCE OF Aspiration of thick mucous material into lungs during a coughing episode
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF Postoperative status, right radical neck dissection for cancer of tongue with wide spread metastasis.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)
1419 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that Dr. A. L. Mooney (this hospital) attended the deceased from May 21, 1968 , to June 20, 1968 , that he/she/it was the attending physician, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A. L. Mooney, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
June 21, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
A. L. MOONEY, M.D. | | | | | 22e. ADDRESS
VAH, Perry Point, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
JUNE 22, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Hills Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Phila. Pa. | | | | |
| 24. FUNERAL DIRECTOR
R. Madison Mitchell ADDRESS
Havre de Grace, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE
JUN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item#9 Film#G402 7/2/68 vmp

08366

08370

| | | | | | |
|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Cecil</i> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>rural - Rising Sun</i>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Calvert Nursing Home</i> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <i>Pa</i> b. COUNTY <i>Chester</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural Oxford</i>
d. STREET ADDRESS
<i>P.O. #1</i> | | |
| 3. NAME OF DECEASED
(Type or print) <i>Frank R. Mallalieu</i> | | | 4. DATE OF DEATH
Month <i>June</i> Day <i>16</i> Year <i>1968</i> | | |
| 5. SEX
<i>M</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Oct 21, 1886</i> | 9. AGE (In years last birthday)
<i>81 7/8 yrs.</i> | IF UNDER 1 YEAR
Months <i>1</i> Days <i>16</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Contractor</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Builder</i> | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Coatesville, Chester Co. Pa</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | |
| 13. FATHER'S NAME
<i>David Mallalieu</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Matthe Rubincan</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>no</i> | | | 16. SOCIAL SECURITY NO.
<i>182-01-5131</i> | | |
| 17. INFORMATION
Address <i>Frank R. Mallalieu, PO Box 68, Oxford, Pa</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Respiratory failure</i>
DUE TO (b) <i>Progressive Cerebral Ischemia</i>
DUE TO (c) <i>several years.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>several minutes</i>
<i>355X</i> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>19</i> p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>16 June, 1968</i> , that (I) (we) last saw the deceased alive on <i>15 June, 1968</i> , and that death occurred at <i>1130 PM</i> , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Russell G. Doyle, M.D.</i> | | | 22b. DATE SIGNED
<i>17 June '68</i> | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Russell G. Doyle, M.D.</i> | | | 22d. ADDRESS
<i>133 Locust St., Oxford, Pa. 19363</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>June 19, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Fairview Cem.</i> | |
| 23d. LOCATION (City, town or county) (State)
<i>Coatesville, Chester Co. Pa</i> | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>RALPH M. REED</i>
<i>Ralph M. Reed</i> | | | ADDRESS
<i>RISING SUN, MD.</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08370

CERTIFICATE OF DEATH

INVESTIGATION OF DEATHS
DIVISION OF HEALTH
STATE OF NEW YORK
COUNTY OF ALBANY
DECEASED
NAME
AGE
SEX
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF CORONER
DATE OF INTERVIEW
PLACE OF INTERVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8, Film G402 7/5/68 km

CERTIFICATE OF DEATH

08367

08371

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Samuel Peter Maloney | | | 2a. DATE OF DEATH
Month Day Year
June 15 1968 | | | 2b. HOUR
1:00 P.M. | | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
June 14, 1910 | | 6. AGE (In years last birthday)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
S. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil Md. | | | |
| 10. CITY OR TOWN OF DEATH
Perry Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VA HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Junk Handler | | 12b. KIND OF BUSINESS OR INDUSTRY
Removal Scrap | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Dist of Col. | | 13b. COUNTY
N/A | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
311 T St., NE | |
| 14. FATHER'S NAME First Middle Last
Peter Maloney | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Josephine Hayes | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
Yes WW II | | 16b. SOCIAL SECURITY NO.
249-14-0883 | | 17. INFORMANT Address
VA Hospital Records, Perry Point, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of stomach far advanced
1519 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Complicated by confluent bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF of both lower lobes
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 years
2 weeks | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
151X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
VA | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 17, 1968 , to June 15, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
B. Rothfeld | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
6-16-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
B. ROTHFELD, M.D. | | | | 22e. ADDRESS
VA HOSPITAL, Perry Point, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
6-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Vaughan Cemetery, | | 23d. LOCATION (City or Town) (County) (State)
Walterboro S.C. | | | |
| 24. FUNERAL DIRECTOR
Patterson & Sons, Perryville, Maryland | | | | ADDRESS
Patterson & Sons, Perryville, Maryland | | 25a. REC'D BY REGISTRAR
DATE JUN 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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CONFIDENTIAL - SECURITY INFORMATION

| Age Group | Percentage |
|-----------|------------|
| 18-29 | 85% |
| 30-49 | 80% |
| 50-69 | 75% |
| 70+ | 70% |

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DATE _____

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3. The following are the names of the persons who have been appointed to the various committees of the Board of Directors:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Viola | | | M. Martin | | | June 26 1968 | | | 3:15 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Female | | White | | Nov. 13, 1918 | | | 49 YRS. | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Virginia | | U.S.A. | | | | | Cecil Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Elkton | | | Union Hospital | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER |
| Maryland | | | Cecil | | | Elkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | R.D. |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| John A. Cox | | | May Poe | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| No | | | | | | Roscoe L. Martin, Elkton, Md. R.D. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>UREMIA</u>
<u>582X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>CHRONIC GLOMERULONEPHRITIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
<u>57 YEARS -</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>592X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>68</u> , to <u>present</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>26 June</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert L. Gray</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>28 June 1968</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert L. Gray | | | | | 22e. ADDRESS
Elkton Medical Park, Elkton, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6/30/68 | | Cox Cemetery | | Independence, Va. | | | |
| 24. FUNERAL DIRECTOR
<u>Napht E. Hicks</u>
Hicks Home for Funerals, Elkton, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JUL - 3 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08369

08373

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point
c. LENGTH OF STAY IN b
D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace
d. STREET ADDRESS
354 Bourbon Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
IVAN M. McMULLEN | | | 4. DATE OF DEATH
Month 6 Day 10 Year 1968 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-28-06 | 9. AGE (In years last birthday)
62 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
RIGGER LEADER | | 11. BIRTHPLACE (State or foreign country)
MD | | | |
| 13. FATHER'S NAME
Oscar McMullen | | | 14. MOTHER'S MAIDEN NAME
Agnes Richardson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Oscar McMullen, Son, Rising Sun, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CRUSHING HEAD INJURY
917X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) TIMBER FALLING ON HEAD
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
9103 | | | | | INTERVAL BETWEEN ONSET AND DEATH
INST.
INST. | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
TIMBER SLIPPED OFF FRONT END LEADER | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
12:45 p.m. 6/10/68 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
FACTORY | 20f. (City or town) (County) (State)
PERRYVILLE CECIL MD | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Henry V. Davis MD | | M.D. | | 22. DATE SIGNED
6/10/68 | | | |
| EXAMINER'S NAME (Type)
HENRY V. DAVIS MD | | ADDRESS
1515 E. BAYVIEW AVE CITY MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 23b. DATE THEREOF
6 10 68 | 23c. NAME OF CEMETERY OR CREMATORY
ROCKY HILL CEM. | | 23d. LOCATION (City or Town) (County) (State)
HARFORD CO. MD. | | | |
| 24. FUNERAL DIRECTOR
R. Madison Mitchell | | ADDRESS
Havre de Grace Md 21078 | | 25a. REC'D BY REGISTRAR
JUN 13 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

MEDICAL CERTIFICATION

4632

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North Carolina 29071

October 1991

U.S. - Mexico Trade Commission

07

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08370

08374

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Warwick
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Catherine Middle C. Last Moffett | | | | 4. DATE OF DEATH Month June Day 15 Year 1968 | | | |
| 5. SEX Female | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 15, 1889 79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) N.C. Co. Delaware | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Michael Carroll | | | | 14. MOTHER'S MAIDEN NAME Sarah Jane Hoover | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address Michael Carroll - Warwick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
403 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Renal neprosclerosis
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) terminally Congestive heart failure .
446A
INTERVAL BETWEEN ONSET AND DEATH one month | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11 June , 19 68 , to 15 June , 19 68 , that (I) (we) last saw the deceased alive on 15 June , 19 68 , and that death occurred at 6 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Wallace Obenshain M.D. | | | | 22b. DATE SIGNED 17 June 68 | | 22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. | |
| 22d. ADDRESS Cecilton, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 6/19/68 | | 23c. NAME OF CEMETERY OR CREMATORY Old Bohemia Cem. | | 23d. LOCATION (City, town or county) (State) Warwick Md. | |
| 24. FUNERAL DIRECTOR D. Lester Daniels - Middletown, Del. | | | | 25a. REC'D BY REGISTRAR JUN 19 1968 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

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| MAY 1968 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 08375 | | | | | | | | | |
|--|--|---------|---|------------------|--|--|--|-----------------|---|---|--|---|--|--|---|--|--|---|--|-------|------------------|--|--|----------|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | | Middle | | | Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | Month | | | Day | | | Year | | | 2b. HOUR | | | | | |
| TIMOTHY | | | MICHAEL | | | MOSE | | | JUNE 15 1968 | | | 1:25 PM | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | Month | | | Day | | | Year | | | 2d. HOUR | | | | | |
| MALE | | WHITE | | SEPT. 3 1952 | | 15 YRS. | | MONTHS | | DAYS | | JUNE | | | 15 | | | 1968 | | | 1:55 PM | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | Md. | | | | | |
| DEL. | | | USA | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | CECIL | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| ELKTON | | | UNION HOSPITAL | | | SCHOOL | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | |
| DEL | | | NEWCASTLE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | MEADOWOOD | | | 170 ROCKROSE DRIVE | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MURTHA | | | PATRICIA | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | | | | | | | | | | | | | |
| NO | | | | | | FATHER - NEWARK, DEL. | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>8109</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>FRACURED SKULL FRONTAL BONE</u>
(c) <u>FRACURED MANDIBLE</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. <u>8104</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>AUTO ACCIDENT IN WHICH AUTO</u>
(c) <u>STUCK TRAIN AT GRADE CROSSING</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>INST.</u> | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS
CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | | | | | | | |
| JUNE 15 1968 | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month Day, Year
HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| CAUSE OF DEATH | | | 12:25 | | | JUNE 15 1968 | | | AUTO STRUCK TRAIN | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (At home/farm, street,
factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County | | | State | | | | | | | | | | | | | | |
| GRADE CROSSING AND STATE 279 | | | INTERSECTION | | | NEAR | | | ELKTON | | | CECIL MD | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | HENRY V. DAVIS | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED | | | | | | | | |
| EXAMINER'S
NAME (Type) | | | HENRY V. DAVIS M.D. | | | | | | | | | | | | | | | | | | 6/15/68 | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) | | | (State) | | | | | | | | | | | | | | |
| BURIAL | | | JUNE 19 1968 | | | ALL SAINTS CEM | | | NEW CASTLE C. | | | DEL. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | |
| PIPPIN FUNERAL HOME | | | ELKTON MD | | | JUN 18 1968 | | | Charles Judge | | | | | | | | | | | | | | | | | | | | |

00375

THE MEDICAL EXAMINER'S REPORT

00375

FOR STATE
RECORD



100-1-100

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08372

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08376

| | | | | | | | | | |
|--|---------------------|--|---|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or Print) James Kay Page | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 7 19 68 12:00 Noon | | | 2b. HOUR | | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
Nov. 18, 1907 | 6. AGE (In years last birthday)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year
8 7 19 68 | | | 2d. HOUR
12:45 |
| 7a. BIRTHPLACE (State or foreign country)
So. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil County | | | |
| 10. CITY OR TOWN OF DEATH
Elkton, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Union Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | | 12b. KIND OF BUSINESS OR OCCUPATION
Wm Perry Point |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Cecil | 13c. CITY OR TOWN
Perryville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
Broad Street | | |
| 14. FATHER'S NAME
Ellis J. Page | | | 15. MOTHER'S MAIDEN NAME
Bertha Price | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Mrs. Lois H. Page, Perryville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
June 8, 1968 | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 11, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Principio Meth. Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Principio, Cecil, Md. | | | |
| 24. FUNERAL DIRECTOR
Lee A. Patterson & Son, Perryville, Md. | | | | ADDRESS
21903 | | 25a. REC'D BY REGISTRAR
JUN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

00376

00376

Nov 18, 1977

Information

1000 W. 10th St.
Oklahoma City, OK 73101

1000 W. 10th St.
Oklahoma City, OK 73101

1000 W. 10th St.
Oklahoma City, OK 73101

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Oklahoma City, OK 73101

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Oklahoma City, OK 73101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 08373 | | | 08377 | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Mary Eunice Pinkerton | | | 2a. DATE OF DEATH Month Day Year
June 28 1968 | | | 2b. HOUR
9 P. M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10--5--1905 | | 6. AGE (In years last birthday) YRS.
62 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil Co. Md. | |
| 10. CITY OR TOWN OF DEATH
North East | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
R.D. #1 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Cecil | | 13c. CITY OR TOWN
North East | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
R.D. # 1 | | 14. FATHER'S NAME First Middle Last
Charles Whitlock | | 15. MOTHER'S MAIDEN NAME First Middle Last
Pearla Mumford | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Ross Pinkerton North East Md. R.D. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
(b) A. S. C. V. D.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 28 1968 , to June 27 1968 , that (I) (we) last saw the deceased alive on June 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ernest W. Seifer | | | | 22c. DATE SIGNED
July 1, 1968 | | 22d. PHYSICIAN'S NAME (Type)
Ernest W. Seifer | |
| 22e. ADDRESS
Rising Sun, Maryland | | | | 22f. ADDRESS
Rising Sun, Maryland | | 22g. ADDRESS
Rising Sun, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
7-1-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Faggs Manor Cem. | | 23d. LOCATION (City or Town) (County) (State)
Russellville Chester Pa. | |
| 24. FUNERAL DIRECTOR
Ernest W. Seifer | | | | 25a. REC'D BY REGISTRAR
JUL - 3 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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[illegible]

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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Chapter 10

1955. 4. 21. 1878

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month 6 Day 18 Year 68 | | 2b. HOUR
8:00AM |
| WILLIAM | | ARTHUR | | RITNER | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12-21-08 | | 6. AGE (In years last birthday)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil | | | | Md. |
| 10. CITY OR TOWN OF DEATH
Perry Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Veterans Administration | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Painter | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1708 16th St., N.W. | | |
| 14. FATHER'S NAME
First Middle Last
William Arthur Ritner | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Ellen Culley | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)
WW II | | 16b. SOCIAL SECURITY NO.
102-03-1815 | | 17. INFORMANT
VH Hospital Records, Perry Point, Md. | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malignant Cachexia</u>
1541 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Rectum with Perforation and Extension throughout Pelvis</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Months
3 Years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
154x | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Oct 19, 1966</u> , to <u>June 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A.L. Mooney M.D. | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
6-18-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
A. L. MOONEY, M.D. | | 22e. ADDRESS
VA Hospital, Perry Point, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/21/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Culpeper Nat. Cem. Culpeper Va. | | 23d. LOCATION (City or Town) (County) (State)
Culpeper Va. | | | | |
| 24. FUNERAL DIRECTOR
Lee A. Patterson & Son Perryville, Md. | | 25a. REC'D BY REGISTRAR
JUN 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-68

| <div>08375</div> <div> <div>MD</div> <div>1</div> </div> <div> <div>08379</div> <div>1</div> </div> | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|--|------------------|--|
| <div> <div>1. DECEASED-NAME
(Type or print)</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div>Chester Alvin Russell</div> | | | | | | <div>2a. DATE OF DEATH</div> <div>Month <u>6</u> Day <u>28</u> Year <u>68</u></div> | | | <div>2b. HOUR</div> <div><u>11 P.</u> M</div> | | | |
| <div>3. SEX</div> <div>Male</div> | | <div>4. RACE</div> <div>White</div> | | <div>5. DATE OF BIRTH</div> <div>May 26, 1961</div> | | <div>6. AGE (In years last birthday)</div> <div>67 YRS.</div> | | <div>IF UNDER 1 YEAR</div> <div>MONTHS DAYS HOURS MIN.</div> | | <div>IF UNDER 24 HRS.</div> <div>HOURS MIN.</div> | | |
| <div>7a. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div> | | <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> | | <div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> | | <div>9. COUNTY OF DEATH</div> <div>Cecil</div> | | | | | | |
| <div>10. CITY OR TOWN OF DEATH</div> <div>Elkton</div> | | <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Union Hospital</div> | | | <div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Logger</div> | | | <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Logging</div> | | | | |
| <div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Maryland</div> | | <div>13b. COUNTY</div> <div>Cecil</div> | | <div>13c. CITY OR TOWN</div> <div>Elkton</div> | | <div>13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> | | <div>13e. STREET AND NUMBER</div> <div>210 Locust Lane</div> | | | | |
| <div>14. FATHER'S NAME First Middle Last</div> <div>James B. Russell</div> | | | | <div>15. MOTHER'S MAIDEN NAME First Middle Last</div> <div>Mary E. Boulden</div> | | | | | | | | |
| <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)</div> <div>No</div> | | <div>16b. SOCIAL SECURITY NO.</div> <div>06 213-58-451</div> | | <div>17. INFORMANT</div> <div>Alice E. Russell</div> | | | | <div>Address</div> <div>210 Locust La. Elkton, Md.</div> | | | | |
| <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u></div> <div>4129</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO, OR AS A CONSEQUENCE OF (b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF (c)</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>Years</div> | | | | | | | | | | | | |
| <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>4200</div> <div>None</div> | | | | | | | | | | | | |
| <div>19a. DATE OF OPERATION</div> | | <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> | | | <div>20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> | | <div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> | | | | | |
| <div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div> | | <div>21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19</div> | | | <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> | | | | | | | |
| <div>21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></div> | | <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> | | | <div>21f. LOCATION Street or R.F.D. No.</div> | | <div>City or Town</div> | | <div>County</div> | | <div>State</div> | |
| <div>22a. I certify that (I) (this hospital) attended the deceased from <u>6-14-1968</u>, to <u>6-28-1968</u>, that (I) (we) lost the deceased alive on <u>6-28-1968</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div> | | | | | | | | | | | | |
| <div>22b. SIGNATURE</div> <div>Tillman D. Johnson M.D.</div> <div>DEGREE</div> | | | | | <div>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div> | | | <div>22c. DATE SIGNED</div> <div>6-29-68</div> | | | | |
| <div>22d. PHYSICIAN'S NAME (Type)</div> <div>Tillman D. Johnson M.D.</div> | | | | | <div>22e. ADDRESS</div> <div>123 Singsley Ave Elkton, Md</div> | | | | | | | |
| <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> | | <div>23b. DATE</div> <div>7-2-68</div> | | <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Bay View Meth.</div> | | | <div>23d. LOCATION (City or Town) (County) (State)</div> <div>Cecil Md.</div> | | | | | |
| <div>24. FUNERAL DIRECTOR</div> <div>Grant Funeral Home</div> | | | | | <div>ADDRESS</div> <div>Box 22 North East, Md.</div> | | | <div>25a. REC'D BY REGISTRAR</div> <div>DATE: JUL - 2 1968</div> | | <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-107
30M REV. 1-68

88376

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

88380

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|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(Type or print)
HARRY SCOTT | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year
June 17, 1968 | | 2b. HOUR
4:30 P.M. | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
2-25-22 | | 6. AGE (In years last birthday)
46 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil Md. | |
| 10. CITY OR TOWN OF DEATH
Perry Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Veterans Administration | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Station Cleaner | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
DC | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
400 Chesapeake St., S.E. | | 14. FATHER'S NAME
First Middle Last
Willie Scott | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Sarah Starkes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
yes WW II | | 16b. SOCIAL SECURITY NO.
578383400 | | 17. INFORMANT
Records VAH, Perry Point, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant hypertension
400.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
445X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from May 21 , 19 68 , to June 17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (and we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
E. E. Folk
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
6-17-68 | |
| 22d. PHYSICIAN'S NAME (Type)
E. E. FOLK, M.D. | | | | 22e. ADDRESS
VA Hospital, Perry Point, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
6-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Frazier Funeral Home, Washington, DC | | | | 25a. REC'D BY REGISTRAR
DATE JUN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-15-68
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|-----------------------------|--|--|--|--|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last
James F. Smith | | | | | | 2a. DATE OF DEATH Month Day Year
6 1 68 | | | 2b. HOUR
4:27 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 2, 1902 | | | 6. AGE (In years last birthday)
65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Cecil Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Elkton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Union Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Assembler | | | 12b. KIND OF BUSINESS OR INDUSTRY
Chrysler | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Cecil | | 13c. CITY OR TOWN
Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Johnstown Rd. R.D.#5 | | |
| 14. FATHER'S NAME First Middle Last
Linton Smith | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Amelia Derflinger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO.
170-07-1135 | | 17. INFORMANT Address
Mrs. Anna M. Smith, Elkton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>4129</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Nephrosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 wks</u>
<u>Years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>446X1. Arteriosclerotic H.D. 2. Pulmonary emboli</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-9-1968</u> , to <u>6-1-1968</u> , that (I) (we) last saw the deceased alive on <u>6-1-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Tillman D. Schansen</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>6-5-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Tillman D. Schansen (M.D.)</u> | | | | | | 22e. ADDRESS
<u>123 Singler Ave. Elkton, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>6/5/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cherry Hill Meth. Cemetery, Cherry Hill, Md.</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Cherry Hill Md.</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>Ralph E. Hicks</u>
<u>Hicks Home for Funerals, Elkton, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>JUN 10 1968</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA FORM 101
304A REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | |
|--|-------------------------|--|---|---|
| 1. DECEASED-NAME
(Type or print) Willie STEWART | | 2a. DATE OF DEATH
Month June 14 , Year 1968 | | 2b. HOUR
1:35 a.m. |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
9-1-24 | | 6. AGE (In years last birthday)
43 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Cecil County | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Perry Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VA Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
District of Columbia | | 13b. COUNTY
Washington | 13c. CITY OR TOWN
Washington | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET AND NUMBER
1301 Fairmont St., N.W. | | | | |
| 14. FATHER'S NAME First Middle Last
Henry Stewart | | 15. MOTHER'S MAIDEN NAME First Middle Last
Amy Blair | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
Yes Korean | | 16b. SOCIAL SECURITY NO.
241-28-88-07 | | 17. INFORMANT Address
VA Hospital Records - Perry Point, Maryland |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
4339 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332x | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-18-68 , 19____, to 6-14-68 , 19____, that I (we) last saw the deceased alive on xxxxxx , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
E. E. Folk, M.D. | | 22c. DATE SIGNED
6-14-68 | | 22d. PHYSICIAN'S NAME (Type)
E. E. FOLK, III, M. D. |
| 22e. ADDRESS
VA Hospital - Perry Point, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
6-18-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto Natl Cemetery |
| 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR
CHAMBERS FUNERAL HOME - Washington, D.C. | | 25a. REC'D BY REGISTRAR
DATE JUN 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print)
First <u>Albert M. Takach</u> also known as Middle <u>BERT</u> Last <u>TOKAS</u> | | | | | 2a. DATE OF DEATH
Month <u>June</u> Day <u>18</u> Year <u>1968</u> | | | 2b. HOUR
<u>3:50</u> PM | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>8-24-93</u> | | 6. AGE (In years last birthday)
<u>74</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
<u>New York</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Cecil</u> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Perryville</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>VAH., Perry Point, Md.</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Janitor</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Delaware</u> | | | 13b. COUNTY
<u>New Castle</u> | | 13c. CITY OR TOWN
<u>Christiana</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>27 S. Old Baltimoe Pike</u> | |
| 14. FATHER'S NAME First <u>JOSEPH</u> Middle <u>TOKAS</u> Last <u>TOKAS</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Pauline</u> Middle <u>ROH</u> Last <u>ROH</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes</u> <u>WWI</u> | | | 16b. SOCIAL SECURITY NO.
<u>063-18-3311</u> | | 17. INFORMANT Address
<u>VAHOSPITAL RECORDS, Perry Point, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Addenocarcinoma of rectum with metastasis</u>
<u>1541</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Schizophrenia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>154x</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <u>VAH</u> (this hospital) attended the deceased from <u>11-13-</u> , <u>1967</u> , to <u>6-18-</u> , <u>1968</u> , and that in (my) <u>VAH</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>VAH</u> (did) <u>not</u> view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>S. Goldgraben M.D.</u> | | | | | | | | 22c. DATE SIGNED
<u>6-18-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>S. GOLDGRABEN, M.D.</u> | | | | 22e. ADDRESS
<u>VAH., Perry Point, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>6/21/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gracelawn Mem.Pk.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Wilmington, Delaware</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>R. T. Jones</u> | | | | ADDRESS
<u>Newark, Del.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 24 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|------------------------------|--|--|---|---|---|--|----------|
| Item#2a, FilmG405 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| ROBERT T. VANDERSLICE | | | | | | Month Day Year | | | ? |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| Male | White | April 9, 1934 | 34 | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 11:30 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Penna | | U.S.A. | | | | Cecil | | U. S. Army | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| | | | woods vic. Conowingo | | | Soldier | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Pa. | | | | | | Avandale | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| late Raymond O Vanderslice | | | Florence Pinkerton | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | 17. INFORMANT ADDRESS | | | |
| Yes | | | K00/TA/80 | | | U. S. Army records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Asphyxia | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) hanging | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 974X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| ? | | | P.M. 2 6 1968 | | Subject hanged himself | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | Woods | | Woods vic. Conowingo 100 yds N. Rt. 1 Cecil Md | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER | | 22b. DATE SIGNED | |
| Edward F. Wilson | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | October 6, 1968 | |
| EXAMINER'S NAME (Type) | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| Edward F. Wilson, M.D. | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Oct. 15 ' 68 | | Fort Benning Post | | Columbus, Georgia | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Howard County Funeral Home of Harry Witzke Ellicott City Maryland | | | | | | OCT 15 1968 | | Charles Judge | |

1997

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08380

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08385

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Union Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
George Ellsworth Whaland | | 4. DATE OF DEATH
Month June Day 20 Year 1968 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/29/1906 |
| 9. AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Watchman for Gravel Company | | 11b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 12. BIRTHPLACE (State or foreign country)
Maryland | | 13. CITIZEN OF WHAT COUNTRY?
USA | |
| 14. FATHER'S NAME
George T. Whaland | | 15. MOTHER'S MAIDEN NAME
Susan Carter | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 17. SOCIAL SECURITY NO.
212 10 9026 | |
| 18. INFORMANT
wife | | Address
Mary Whaland Chesapeake City, Md. | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4129 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
INTERVAL BETWEEN ONSET AND DEATH
Over 2 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
4200 None | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH
N/A | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
No injury | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. No injury | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work Home | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Chesapeake City, Cecil, Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Tillman D. Johnson M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Tillman D. Johnson M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
6-20-68 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county)
123 Sinkerly Ave, Elkton | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/22/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Chester Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Chestertown, Md. | |
| 24. FUNERAL DIRECTOR
J. Williams | | ADDRESS
Chestertown, Md. | |
| 25a. REC'D BY REGISTRAR
J. Williams | | 25b. REGISTRAR'S SIGNATURE
J. Williams | |
| DATE
JUN 24 1968 | | | |

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1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Bertha | | J. | | Williams | | Williams | | Month Day Year
June 8, 1968 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Female | | Cau. | | Sept. 23, 1885 | | | | 82 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Cecil Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Calvert | | Calvert Manor Nursing Home | | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Cecil | | Port Deposit | | | | Rt 222 | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| James | | F. | | Rutter | | | | Minerva | | V. Lynch | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| No | | 220-54-9690 | | Walton C. Williams, Port Deposit, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4221 Congestive Heart Failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1961, to June 3, 1968, that (I) (we) lost soul the deceased alive on June 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| Ernest W. Seiter M.D. | | June 7, 1968 | | | | Ernest W. Seiter M.D. | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | | | | |
| Rising Sun, Maryland | | Rising Sun, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | June 6, 1968 | | Hopewell Cemetery | | Port Deposit, Cecil, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | | | | | | | | |
| Lee A. Patterson & Son, Perryville, Md. | | DATE JUN 11 1968 | | | | | | | | | |

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1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

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